Organization Name:
Center for Health Systems Research and Analysis, University of Wisconsin – Madison

Contact Person:
Sara Karon, Ph.D.
Center for Health Systems Research & Analysis
610 Walnut Street, 11th floor
Madison, WI 53726
(608) 262-6900
(608) 263-4523 fax
sara@chsra.wisc.edu

Organizational Description:

The Center for Health Systems Research and Analysis (CHSRA) was formed in 1973 as a collaborative effort between the departments of Industrial Engineering and Preventive Medicine at the University of Wisconsin-Madison. Over the years, CHSRA's interdisciplinary staff has applied a range of techniques to address a variety of issues in long-term care, mental health, dental health, addiction treatment, injury prevention, and other issues.

CHSRA has a significant research interest in the development of indicator/measurement systems which can target problem areas in need of improvement for long-term care providers including nursing homes, home health agencies, intermediate care facilities for the mentally retarded, assisted living facilities, and home- and community-based service providers. In addition to indicator/measurement system development, CHSRA is also strongly committed to identifying, developing and testing techniques and methods for long-term care providers to improve care delivery to the people they serve. CHSRA's long-term care initiatives have focused on the development and use of indicators/measures by public quality assurance agencies, individual long-term care providers, long-term care provider networks, and consumers.

Numerous initiatives are underway in both the public and private sector to use technology and other media to increase the availability of consumer health information. CHSRA staff are involved in a variety of projects that involve providing health care information to consumers, studying ways to help consumers make health care decisions, and evaluating the effectiveness of consumer information and decision support efforts.

In addition to health care quality research, for which it is best known, CHSRA is also involved in analyses of health reimbursement and payment systems within both the public and private sectors. Staff expertise ranges from actuarial modeling of the financial aspects of these systems to research assessing beneficiary understanding of health care financing options.

Researchers at CHRSA conduct analyses of injury data to improve safety and injury-control decision making. And, finally, CHSRA researchers have developed the Comprehensive Health Enhancement Support System (CHESS)—a computer-based health resource designed to educate and equip people facing a health crisis. CHSRA staff also are serving as a national program office for project to improve the success of addiction treatment programs.

Interest in Planning and Implementation of Long-Term Care Reform:

The Center for Health Systems Research and Analysis (CHSRA) at the University of Wisconsin – Madison has a long-standing interest in supporting the provision of high-quality, cost-effective long-term care, and a long history of using those interests in the services of the State. With this response to the RFI, CHSRA describes its specific interests relative to the State's new long-term care initiative and how those interests can support the successful implementation of this new approach to the statewide provision of long-term care services.

The State of Wisconsin is seeking to improve long-term care services and supports to its citizenry through implementation of managed long-term care programs statewide. While some individuals currently receive long-term care services through managed care programs (e.g., Partnership, Family Care), most are served on a fee-for-service basis. By transitioning all long-term care services to a managed care approach, the State seeks to increase efficiency, improve outcomes, and streamline access to services.

The State plans to contract with a variety of regional managed care organizations (MCOs), each of which may use a unique approach to the management and delivery of services. As with any publicly funded program, it is important for the State to monitor the program to ensure that the desired results are being obtained. It is especially important to ensure that individuals do not experience a loss of access or reduction in quality as a result of this change. The variety of approaches that managed care organizations may use present the State with a further challenge – to ensure that citizens across regions are receiving adequate benefits – as well as a unique opportunity to assess the relative merits of the different approaches.

Clearly there is a need for the State to receive information about access, consumer outcomes, satisfaction, and costs of the various programs. While each program must provide such information to the State, the State will benefit most if data are provided in a comparable way across programs. A single approach to quality and cost management will not only benefit the State by enabling it to monitor individual programs, it also will benefit the State and each managed care program by enabling meaningful comparisons across programs.

With this response to the State's DHFS, CHSRA is offering assistance in developing information systems to support a consistent, systematic approach to monitoring and improving the quality and efficiency of the proposed managed long-term care system. The proposed system would support routine monitoring, ongoing and special analyses of quality and efficiency. It could be used to understand and support the coordination of managed LTC services with other services not provided by the managed care organization, in general, and for specific populations such as people with need for mental health or AODA services. While this latter population is not the specific focus of the proposed LTC programs, many people who will be enrolled in these programs do have significant need for assistance in these areas.

Geographic Area of Interest:

Statewide

Proposed Scope or Nature of Program:

A uniform quality and cost management system should include two key activities. First, it must provide an efficient approach to using the data to generate reports that support both State and MCO/provider quality activities. This includes the ability to readily obtain reports that document and compare performance across MCOs, and within MCOs across counties, providers, target populations, or other important disaggregations. Second, the system should support on-going and special analyses. Ongoing analyses of importance to the State might include issues of performance thresholds, case-mix and risk-adjustment. Special analyses might be one-time or infrequent analyses to support policy (e.g., comparison of costs, access, and outcomes under managed care with fee-for-service), or special analyses to evaluate the likely impact of proposed policy changes.

The Center for Health Systems Research and Analysis (CHSRA) has extensive experience in the development and operation of quality monitoring systems, both for purposes of external quality monitoring and for internal quality improvement.

Data

Data to support an information system of the type envisioned comes from a variety of sources, all of which CHSRA has experience using. Some of the most important data sources include the following.

- **MDS.** The Minimum Data Set (MDS) contains data about all nursing home residents, collected at least quarterly. MDS data can be used to calculate Quality Indicators (QIs) and Quality Measures (QMs) for which national comparison data are available. CHSRA currently receives MDS data from Wisconsin for use in reimbursement modeling, and also receives national MDS data for other purposes. CHSRA routinely uses the MDS data to calculate QIs and QMs, conduct analyses of relative performance, provide data to individual and corporate nursing home providers, and evaluate the impact of quality improvement initiatives.
- **LTCFS.** Wisconsin's Long Term Care Functional Screen (LTCFS) is used to determine eligibility and level of care for long-term services for all Medicaid recipients. Data are collected upon application for long-term services and supports, and annually thereafter. CHSRA (Karon et al., 2005) has recently developed operational definitions for suggested QIs that could be defined based on the LTCFS and a Supplement to the LTCFS developed for use by COP staff.
- **Medicaid claims/encounter data.** The Wisconsin Medicaid program has developed encounter data to mirror claims data, for use by managed care programs. CHSRA has experience working with both claims and encounter data, and in using those data for purposes of quality monitoring and improvement. As part of the Wisconsin SSI Managed Care Program (Milwaukee), CHSRA is receiving encounter data and associated QIs, and using those data to develop routine quality reports, monitor trends, assess performance relative to performance thresholds (benchmarks), and identify quality concerns as they arise.
- **OASIS.** OASIS data are collected by home health care agencies as part of routine assessment of client needs and delivery of care. CHSRA has developed QIs based upon OASIS data.
- **CAHPS.** Under contract to CMS, CHSRA staff were involved in the development use of CAHPS surveys for people to assess the experience of people who voluntarily

disenrolled from Medicare managed care programs, and another study which used CAHPS surveys to assess the impact on people who were disenrolled from Medicare managed care programs when those programs ended. In their current role as part of the External Advocates for the SSI Managed Care Program (Milwaukee), CHSRA will receive CAHPS data and associated QIs, and will use them to analyze the quality performance of MCOs.

- **Other potential data sources.** CHSRA has experience with numerous other data sources that one or more of the MCOs might choose to use, or which the State might select as a required source of quality-related information. CHSRA staff have experience working with data from several quality measurement systems that have been developed for use with people receiving long-term care services in the community due to age, physical disability, or developmental disability. These include the *Personal Experience Surveys,* which were developed under contract to CMS and are available for State use to evaluate the quality of the experiences of people receiving Medicaid services due to developmental disability, age, or physical disability; *Personal Outcome Measures,* which are a proprietary set of outcomes available through the Council on Quality and Leadership, and which were used by the Partnership Program from 2001-2005; the *National Core Indicators,* developed by HSRI and the National Association of State Directors of Developmental Disabilities Services, which measure quality at a state level and currently are used by 24 states and 2 regions of California; and the *MDS-HC,* which was developed by InterRAI as a parallel to the MDS for use in home care, and on the basis of which CHSRA has developed a set of quality indicators that can be used to compare outcomes in home settings with similar outcomes in nursing homes. CHSRA staff also have worked extensively with *Medicare claims* data, which could be used to obtain a more complete picture of services received by people who dually eligible; and data from CMS' *Online Survey, Certification, and Reporting (OSCAR)* database, which can be used to obtain information about the structure (e.g., ownership, size, staffing) and quality (based on survey findings) of organizations including nursing homes and home health agencies.

Based upon our review of the current Partnership and Family Care MCO contracts and operational guidelines, it appears likely that the future long-term care MCOs will use all or some of these data sources. Other likely data sources include event data (e.g., deaths); enrollment data (e.g., intake, level of care, disenrollment); enrollee appeals and complaints; enrollee satisfaction surveys (other than those listed above); and provider-specific data such as the current provider network, provider compliance, conformance with MCO-documented provider qualifications, provider terminations for quality reasons, state survey deficiency citations, and provider staffing information. CHSRA has experience with all of these data sources as well.

Data reports and usage

The various sources of information can be used to create quality indicators or other measures such as might appear on a dashboard system or be used to produce routine reports summarizing and comparing MCO activities and results. Reports can be used to target MCOs for additional attention by DHFS or external quality review organization

(EQRO) staff. CHSRA has extensive experience in the development of quality indicator systems. Appropriate risk adjustment of reported values to reflect differences in enrollee characteristics and service requirements will help provide more meaningful comparisons among MCOs.

Standards for reported results may be expressed in absolute or relative terms. For example, frequency of enrollee influenza vaccinations might be subject to clinically established minimums based on the characteristics of the enrollee. On the other hand, enrollee satisfaction with care planning might be flagged for prompt investigation if it falls in the bottom quartile of MCO results at any point or if it drops by more than 10% from prior levels. CHSRA can assist with the development, testing, and refinement of standards used over time.

Report layouts can target different audiences. An overall report showing the distribution of results among all LTC MCOs would allow DHFS and the EQRO to easily identify outliers. Reports comparing each MCO's results to the average of all MCOs and indicating the percentile placement of the MCO among its peers would assist the MCO in identifying areas of concern for its QA/QI process. If MCO enrollment by Medicaid eligibles is voluntary, a report providing comparative performance values among competing MCOs in a service area or between an MCO and the FFS alternatives may be appropriate. Within an MCO, reports comparing sub-units such as counties (within a multi-county MCO) or providers (when the MCO contracts with multiple providers of a service) can help the MCO to identify more specific areas of concern. CHSRA has extensive experience in developing and implementing these types of reports.

Method

CHSRA proposes developing a set of quality indicators, based on existing measures where possible or developing new indicators where necessary. Development of the set of quality indicators will be conducted in consultation with an advisory council comprised of representatives of the managed care organizations, DHFS, and consumers. Whenever possible, quality indicators will address outcomes that are comparable across populations – frail elders, physically disabled, developmentally disabled – and will use case mix adjustment as appropriate. When needed, population-specific indicators will be used.

The necessary data will be obtained from DHFS or the managed care organizations, using methods to be spelled out under Data Use and Business Associate Agreements. CHSRA will use the necessary data to create the quality indicators. CHSRA also will develop routine and custom reports to be provided to DHFS staff and managed care organizations on a routine basis. Depending on the State's preferences, CHSRA could develop a secure computer interface, similar to that which it has developed for use in other projects, such that DHFS and managed care organizations can obtain customized reports upon demand.

While it is possible to make extensive use of the available data, it also is possible to become overwhelmed by the available data and lose the ability to make good use of it. CHSRA staff can provide end-user training and support, to help ensure that the data are well used and truly support the desired ends of quality and efficiency.

We hope to speak with the State's representatives to discuss this opportunity further.